STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
HEALTH CLAIMS BUREAU
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013
www.insurance.ca.gov
CSD-003-IMR
Eff: 06/01/2014

Dave Jones, Insurance Commissioner

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

If you wish to give authority to someone to assist you in filing this *Independent Medical Review (IMR)*, please complete the *Authorization for Release of Medical Records and Designation of Independent Medical Review Agent* form.

Patient's Name:		
Patient's Parent/Guardian, if filing for Minor Child:		
Patient's Date of Birth:	Patient's Gender: ☐ Male ☐ Female	
Address:		
Email:	Daytime Phone: ( )	Alternate Phone: ( )

The following information is used for statistics only. Providing this information is optional and will not affect the independent medical review process in any way.

Primary language spoken at home if other than English (*Optional)*:
In order to ensure all Californians have access to health insurance, please identify your race/ethnicity (*Optional):*

Complete name of insurance company involved:	
Policy/Certificate number:	Claim number:
Date(s) of Medical Services Provided (if applicable):	
Did your insurance company say the treatment you want is (check one): ☐ Not Medically Necessary ☐ Experimental or Investigational ☐ Other	
If there is an imminent and serious threat to the health of the insured or claimant, please check and indicate the diagnosis: ☐ Diagnosis: _____	
Briefly describe the disputed medical service or expense that you want referred to the Independent Medical Review Organization and list the physicians who have treated you for this condition. Use additional paper as needed.	

I hereby request Independent Medical Review of my dispute with the insurer. I authorize the release of any and all of my medical records and information, of any type, of or pertaining to the scope of this authorization including medical, mental health, substance abuse, HIV records, diagnostic imaging reports, and any other type of non-documentary records, as well as pertinent non-medical records and information. This authorizes release by and among all medical providers, the insurer, the California Department of Insurance and any Independent Medical Review Organization. Release and disclosure are authorized only to the extent any of those persons or entities may deem appropriate for a purpose consistent with the review of a complaint regarding health care services. This authorization will expire one year from the date below, except as regarding the Department's internal use or as otherwise allowed by law. The expiration will apply to all information not previously released pursuant to this authorization. This authorization may be revoked or withdrawn at any time. A revocation or withdrawal will apply to all information not previously release pursuant to this authorization. I attest that the information provided is accurate and truthful.

Please provide any supporting documentation you may have related to this matter.
☐ Copy of insured's insurance identification card – both sides
☐ Copies of correspondence between you and the insurance company including all related Explanation of Benefits (EOBs)

Please be aware that a copy of your Application for Independent Medical Review and your supporting documentation will be provided to the insurance company and the Independent Medical Review Organization.

Patient (or Parent/Guardian if Minor Child) Signature _____ Date _____

If you are not submitting this form electronically, mail or fax your form and any attachments to: Department of Insurance, Health Claims Bureau, 300 South Spring Street, South Tower Los Angeles, CA 90013; FAX: 213-897-9641

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INFORMATION AND INSTRUCTIONS REGARDING YOUR APPLICATION FOR INDEPENDENT MEDICAL REVIEW

Before you request an Independent Medical Review with the Department of Insurance, you are required to first file an appeal/grievance with the insurance company in an effort to resolve the issue(s). If you do not receive a satisfactory response after 30 days, then complete the application form, attach copies of any important papers that relate to your complaint and mail to the address shown on the application form. You may also attach additional sheets as necessary to explain and/or describe the situation and disagreement with your insurance company. We consider this information necessary to our review and within the powers and duties expressed in the California Insurance Code, Section 12921.3 and Section 10169. Please review our privacy statement regarding information we obtain from you.

You have the right to provide information or documentation you believe will support your position in this review.

You may inspect the information you submit at any time as long as the department's case is maintained. All original documents will be returned to you upon completion of our handling.

APPLICATION FOR INDEPENDENT MEDICAL REVIEW MAY BE SUBMITTED TO THE DEPARTMENT OF INSURANCE FOR THE FOLLOWING TYPES OF PROBLEMS:

1. Denial of a claim due to the company's opinion that the treatment or service is not medically necessary or that it is experimental and excluded by a policy provision.
2. An offer of an amount less than that indicated in the policy due to the company's opinion of medical necessity.
3. Delay in settlement of a claim due to the disputed issue of medical necessity.
4. Denial of a claim for urgent or emergency services.

Under the Independent Medical Review process, one or more physicians will determine these issues and their decision will be binding on the insurance company.

Please be aware that a copy of this Application for Independent Medical Review will be provided to the insurance company. Also, please be advised that:

- A decision not to participate in the independent review process may cause the forfeiture of any statutory right to pursue legal action against the insurer regarding the disputed health care service.
- Your consent to obtain any necessary medical records from the insurer, any of its contracting providers, and any out-of-plan provider the insured may have consulted on the matter, is necessary to be signed by you.
- You have the right to provide information or documentation, either directly or through your provider, regarding any of the following:
- The provider's recommendation indicating that the disputed health care service is medically necessary for the insured's medical condition.
- Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the insured's medical condition.
- Reasonable information supporting your position that the disputed health care service is or was medically necessary for the medical condition, including all information provided to the insured by the insurer or any of its contracting providers, still in the possession of the insured, concerning an insurer or provider decision regarding disputed health care services, and a copy of any materials the insured submitted to the insurer, still in the possession of the insured, in support of the grievance, as well as any additional material that the insured believes is relevant.

If you are not submitting this form electronically, mail or fax your form and any attachments to: Department of Insurance, Health Claims Bureau, 300 South Spring Street, South Tower Los Angeles, CA 90013; FAX: 213-897-9641

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND DESIGNATION OF INDEPENDENT MEDICAL REVIEW AGENT

In accordance with California Insurance Code section 10169(e), an insured may designate an agent to act on his or her behalf to assist that insured with the Independent Medical Review (IMR) process. If you want to give another person the authority to assist you with your Independent Medical Review (IMR), complete Parts A and B below.

Unless you wish to designate another person to assist you with the IMR process, if you are a parent or legal guardian filing this IMR for a child under the age of 18, you do not need to complete this form, but you must complete the Application for Independent Medical Review (IMR).

If you are filing this IMR or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also, attach a copy of the power of attorney for the health care decisions or other documents that say you can make decisions for the patient.

PART A: Patient/Insured:
I allow the person named below in Part B to assist me in my IMR filed with the California Department of Insurance (CDI). I allow the CDI and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information. I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing. This authorization will expire one year from the date below, except as regarding the Department's internal use or as otherwise allowed by law.

Name of Patient (Print): _____

Signature of Patient or Insured: _____ Date: _____

PART B: Person Assisting Patient with IMR

Name of Person Assisting (print)_____

Signature of Person Assisting _____

Address_____

Relationship to Patient_____

Daytime Phone #_____

Evening Phone #_____

Email Address (if available): _____

☐ My power of attorney for health care decisions or other legal documents is attached.

If you are not submitting this form electronically, mail or fax your form and any attachments to: Department of Insurance, Health Claims Bureau, 300 South Spring Street, South Tower Los Angeles, CA 90013; FAX: 213-897-9641